Senate Bill 140

By: Senators Williams of the 19th and Cagle of the 49th

AS PASSED

AN ACT

To amend Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to managed health care plans, so as to create the Joint Committee to Study Prescription Costs in State Funded Health Care Plans; to provide for its membership, operation, and duties; to provide for automatic repeal; to amend Article 2 of Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to the patient s right to independent review, so as to revise and add definitions; to change references to conform to revised and new terms; to amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, so as to strike Code Section 49-4-156, which is reserved, and inserting a new Code Section 49-4-156 to provide that certain requirements shall not apply to health maintenance organizations which contract with the department of community health; to amend Article 13 of Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to PeachCare for Kids, so as to provide for a definition; to change certain provisions relating to the creation of PeachCare, availability, eligibility, payment of premiums, and enrollment; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to managed health care plans, is amended by adding a new article to the end of such chapter to read as follows:

ARTICLE 4

33-20A-70.

(a) There is created as a joint committee of the General Assembly the Joint Committee to Study Prescription Costs in State Funded Health Care Plans. The committee shall be composed of three members of the House of Representatives to be appointed by the Speaker of the House of Representatives and three members of the Senate to be appointed

by the President Pro Tempore of the Senate. The members of the committee shall be appointed no later than May 1, 2005. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each designate one of the members appointed to serve as cochairpersons of the committee. The committee shall meet at the call of the cochairpersons.

(b) The committee may conduct such meetings at such places and at such times as it may deem necessary or convenient to enable it to exercise fully and effectively its powers, perform its duties, and accomplish the objectives and purposes of this Code section.

(c) The committee shall study and review prior authorization, formularies, and any other related issues with respect to coverage of prescription drugs under any state funded health care plans, including, but not limited to, plans and health care services offered, established, and provided pursuant to Article 1 of Chapter 18 of Title 45, Article 7 of Chapter 4 of Title 49, and Article 13 of Chapter 5 of Title 49. In the event the committee makes a report of its findings and recommendations, with suggestions for proposed legislation, if any, such report shall be made on or before December 31, 2005.

(d) The Department of Community Health shall cooperate with the committee and its authorized personnel in order that the committee may efficiently and effectively carry out its duties. The Department of Community Health shall submit to the committee such reports and data as the committee shall reasonably require of said department in order that the committee may adequately inform itself.

(e) The members of the committee shall receive the same expenses and allowances for their services on the committee as are authorized by law for members of interim legislative study committees. The expenses and allowances authorized by this subsection shall not be received by any member of the committee for more than five days unless additional days are authorized by the Speaker of the House of Representatives and the President Pro Tempore of the Senate. The funds necessary for the purposes of the committee shall come from the funds appropriated to and available to the legislative branch of government.

(f) The committee shall stand abolished and this Code section shall be automatically repealed on December 31, 2005.

SECTION 2.

Article 2 of Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to the patient s right to independent review, is amended by striking such article in its entirety and inserting in lieu thereof a new Article 2 to read as follows:

ARTICLE 2

33-20A-30.

This article shall be known and may be cited as the 'Patient s Right to Independent Review Act.'

33-20A-31.

As used in this article:

(1) 'Department' means the Department of Community Health established under Chapter 5A of Title 31.

(2) 'Eligible enrollee' means a person who:

(A) Is an enrollee or an eligible dependent of an enrollee of a managed care plan or was an enrollee or an eligible dependent of an enrollee of such plan at the time of the request for treatment;

(B) Seeks a treatment which reasonably appears to be a covered service or benefit under the enrollee s evidence of coverage; provided, however, that this subparagraph shall not apply if the notice from a managed care plan of the outcome of the grievance procedure was that a treatment is experimental; and

(C) Is not a Medicaid care management member.

(3) 'Grievance procedure' means the grievance procedure established pursuant to Code Section 33-20A-5.

(4) 'Independent review organization' means any organization certified as such by the department under Code Section 33-20A-39.

(5) 'Medicaid care management member' means a recipient of medical assistance, as that term is defined in paragraph (7) of Code Section 49-4-141, and shall also include a child receiving health care benefits pursuant to Article 13 of Chapter 5 of Title 49.

(6) 'Medical and scientific evidence' means:

(A) Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

(C) Medical journals recognized by the United States secretary of health and human services, under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; or

(E) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, the Centers for Medicare and Medicaid Services, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(7) 'Medical necessity,' 'medically necessary care,' or 'medically necessary and appropriate' means care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

(A) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee s condition;

(B) Compatible with the standards of acceptable medical practice in the United States;

(C) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

(D) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and

(E) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee s evidence of coverage.

(8) 'Treatment' means a medical service, diagnosis, procedure, therapy, drug, or device.

(9) Any term defined in Code Section 33-20A-3 shall have the meaning provided for that term in Code Section 33-20A-3 except that 'enrollee' shall include the enrollee s eligible dependents.

33-20A-32.

An eligible enrollee shall be entitled to appeal to an independent review organization when:

(1) The eligible enrollee has received notice of an adverse outcome pursuant to a grievance procedure or the managed care entity has not complied with the requirements of Code Section 33-20A-5 with regard to such procedure; or

(2) A managed care entity determines that a proposed treatment is excluded as experimental under the managed care plan, and all of the following criteria are met:

(A) The eligible enrollee has a terminal condition that, according to the treating physician, has a substantial probability of causing death within two years from the date of the request for independent review or the eligible enrollee s ability to regain or maintain maximum function, as determined by the treating physician, would be impaired by withholding the experimental treatment;

(B) After exhaustion of standard treatment as provided by the evidence of coverage or a finding that such treatment would be of substantially lesser or of no benefit, the eligible enrollee s treating physician certifies that the eligible enrollee has a condition for which standard treatment would not be medically indicated for the eligible enrollee or for which there is no standard treatment available under the evidence of coverage of the eligible enrollee more beneficial than the treatment proposed;

(C) The eligible enrollee s treating physician has recommended and certified in writing treatment which is likely to be more beneficial to the eligible enrollee than any available standard treatment;

(D) The eligible enrollee has requested a treatment as to which the eligible enrollee s treating physician, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the eligible enrollee s condition, has certified in writing that scientifically valid studies using accepted protocols, such as control group or double-blind testing, published in peer reviewed literature, demonstrate that the proposed treatment is likely to be more beneficial for the eligible enrollee than available standard treatment; and

(E) A specific treatment recommended would otherwise be included within the eligible enrollee s certificate of coverage, except for the determination by the managed care entity that such treatment is experimental for a particular condition.

33-20A-33.

Except where required pursuant to Code Section 51-1-49, a proposed treatment must require the expenditure of a minimum of $500.00 to qualify for independent review.

33-20A-34.

(a) The parent or guardian of a minor who is an eligible enrollee may act on behalf of the minor in requesting independent review. The legal guardian or representative of an incapacitated eligible enrollee shall be authorized to act on behalf of the eligible enrollee in requesting independent review. Except as provided in Code Section 51-1-49, independent review may not be requested by persons other than the eligible enrollee or a person acting on behalf of the eligible enrollee as provided in this Code section.

(b) A managed care entity shall be required to pay the full cost of applying for and obtaining the independent review.

(c) The eligible enrollee and the managed care entity shall cooperate with the independent review organization to provide the information and documentation, including executing necessary releases for medical records, which are necessary for the independent review organization to make a determination of the claim.

33-20A-35.

(a) In the event that the outcome of the grievance procedure under Code Section 33-20A-5 is adverse to the eligible enrollee, the managed care entity shall include with the written notice of the outcome of the grievance procedure a statement specifying that any request for independent review must be made to the department on forms developed by the department, and such forms shall be included with the notification. Such statement shall be in simple, clear language in boldface type which is larger and bolder than any other typeface which is in the notice and in at least 14 point typeface.

(b) An eligible enrollee must submit the written request for independent review to the department. Instructions on how to request independent review shall be given to all eligible enrollees with the written notice required under this Code section together with instructions in simple, clear language as to what information, documentation, and procedure are required for independent review.

(c) Upon receipt of a completed form requesting independent review as required by subsection (a) of this Code section, the department shall notify the eligible enrollee of receipt and assign the request to an independent review organization on a rotating basis according to the date the request is received.

(d) Upon assigning a request for independent review to an independent review organization, the department shall provide written notification of the name and address of the assigned organization to both the requesting eligible enrollee and the managed care entity.

(e) No managed care entity may be certified by the Commissioner under Article 1 of this chapter unless the entity agrees to pay the costs of independent review to the independent review organization assigned by the department to conduct each review involving such entity s eligible enrollees.

33-20A-36.

(a) Within three business days of receipt of notice from the department of assignment of the application for determination to an independent review organization, the managed care entity shall submit to that organization the following:

(1) Any information submitted to the managed care entity by the eligible enrollee in support of the eligible enrollee s grievance procedure filing;

(2) A copy of the contract provisions or evidence of coverage of the managed care plan; and

(3) Any other relevant documents or information used by the managed care entity in determining the outcome of the eligible enrollee s grievance.

Upon request, the managed care entity shall provide a copy of all documents required by this subsection, except for any proprietary or privileged information, to the eligible enrollee. The eligible enrollee may provide the independent review organization with any additional information the eligible enrollee deems relevant.

(b) The independent review organization shall request any additional information required for the review from the managed care entity and the eligible enrollee within five business days of receipt of the documentation required under this Code section. Any additional information requested by the independent review organization shall be submitted within five business days of receipt of the request, or an explanation of why the additional information is not being submitted shall be provided.

(c) Additional information obtained from the eligible enrollee shall be transmitted to the managed care entity, which may determine that such additional information justifies a reconsideration of the outcome of the grievance procedure. A decision by the managed care entity to cover fully the treatment in question upon reconsideration using such additional information shall terminate independent review.

(d) The expert reviewer of the independent review organization shall make a determination within 15 business days after expiration of all time limits set forth in this Code section, but such time limits may be extended or shortened by mutual agreement between the eligible enrollee and the managed care entity. The determination shall be in writing and state the

basis of the reviewer s decision. A copy of the decision shall be delivered to the managed care entity, the eligible enrollee, and the department by at least first-class mail.

(e) The independent review organization s decision shall be based upon a review of the information and documentation submitted to it.

(f) Information required or authorized to be provided pursuant to this Code section may be provided by facsimile transmission or other electronic transmission.

33-20A-37.

(a) A decision of the independent review organization in favor of the eligible enrollee shall be final and binding on the managed care entity and the appropriate relief shall be provided without delay. A managed care entity bound by such decision of an independent review organization shall not be liable pursuant to Code Section 51-1-48 for abiding by such decision. Nothing in this Code section shall relieve the managed care entity from liability for damages proximately caused by its determination of the proposed treatment prior to such decision.

(b) A determination by the independent review organization in favor of a managed care entity shall create a rebuttable presumption in any subsequent action that the managed care entity s prior determination was appropriate and shall constitute a medical record for purposes of Code Section 24-7-8.

(c) In the event that, in the judgment of the treating health care provider, the health condition of the enrollee is such that following the provisions of Code Section 33-20A-36 would jeopardize the life or health of the eligible enrollee or the eligible enrollee s ability to regain maximum function, as determined by the treating health care provider, an expedited review shall be available. The expedited review process shall encompass all elements enumerated in Code Sections 33-20A-36 and 33-20A-40; provided, however, that a decision by the expert reviewer shall be rendered within 72 hours after the expert reviewer s receipt of all available requested documents.

33-20A-38.

Neither an independent review organization nor its employees, agents, or contractors shall be liable for damages arising from determinations made pursuant to this article, unless an act or omission thereof is made in bad faith or through gross negligence, constitutes fraud or willful misconduct, or demonstrates malice, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to the consequences.

33-20A-39.

(a) The department shall certify independent review organizations that meet the requirements of this Code section and any regulations promulgated by the department consistent with this article. The department shall deem certified any independent review organization meeting standards developed for this purpose by an independent national accrediting organization. To qualify for certification, an independent review organization must show the following:

(1) Expert reviewers assigned by the independent review organization must be physicians or other appropriate providers who meet the following minimum requirements:

(A) Are expert in the treatment of the medical condition at issue and are knowledgeable about the recommended treatment through actual clinical experience;

(B) Hold a nonrestricted license issued by a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, government, or regulatory body;

(2) The independent review organization shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association of health plans, a managed care entity, or a professional association of health care providers; and

(3) The independent review organization shall submit to the department the following information upon initial application for certification, and thereafter within 30 days of any change to any of the following information:

(A) The names of all owners of more than 5 percent of any stock or options, if a publicly held organization;

(B) The names of all holders of bonds or notes in excess of $100,000.00, if any;

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization s type of business; and

(D) The names of all directors, officers, and executives of the independent review organization, as well as a statement regarding any relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care entity or organization, provider group, or board or committee.

(b) Neither the independent review organization nor any expert reviewer of the independent review organization may have any material professional, familial, or financial conflict of interest with any of the following:

(1) A managed care plan or entity being reviewed;

(2) Any officer, director, or management employee of a managed care plan which is being reviewed;

(3) The physician, the physician s medical group, health care provider, or the independent practice association proposing a treatment under review;

(4) The institution at which a proposed treatment would be provided;

(5) The eligible enrollee or the eligible enrollee s representative; or

(6) The development or manufacture of the treatment proposed for the eligible enrollee whose treatment is under review.

(c) As used in subsection (b) of this Code section, the term 'conflict of interest' shall not be interpreted to include a contract under which an academic medical center or other similar medical research center provides health care services to eligible enrollees of a managed care plan, except as subject to the requirement of paragraph (4) of subsection (b) of this Code section; affiliations which are limited to staff privileges at a health care facility; or an expert reviewer s participation as a contracting plan provider where the expert is affiliated with an academic medical center or other similar medical research center that is acting as an independent review organization under this article. An agreement to provide independent review for an eligible enrollee or managed care entity is not a conflict of interest under subsection (b) of this Code section.

(d) The independent review organization shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(e) The department shall provide upon the request of any interested person a copy of all nonproprietary information filed with it pursuant to this article. The department shall provide at least quarterly a current list of certified independent review organizations to all managed care entities and to any interested persons.

33-20A-40.

(a) For the purposes of this article, in making a determination as to whether a treatment is medically necessary and appropriate, the expert reviewer shall use the definition provided in paragraph(7) of Code Section 33-20A-31.

(b) For the purposes of this article, in making a determination as to whether a treatment is experimental, the expert reviewer shall determine:

(1) Whether such treatment has been approved by the federal Food and Drug Administration; or

(2) Whether medical and scientific evidence demonstrates that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that the adverse risks of the proposed treatment will not be substantially increased over those of standard treatments.

For either determination, the expert reviewer shall apply prudent professional practices and shall assure that at least two documents of medical and scientific evidence support the decision.

33-20A-41.

The department shall provide necessary rules and regulations for the implementation and operation of this article.

33-20A-42.

Medicaid care management members shall, after first exhausting the grievance procedure of the managed care plan providing health care benefits pursuant to Article 7 of Chapter 4 of Title 49 or Article 13 of Chapter 5 of Title 49, be afforded the fair hearing rights provided pursuant to Code Section 49-4-153 or the state plan provided for in Article 13 of Chapter 5 of Title 49.

SECTION 3.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, is amended by striking Code Section 49-4-156, which is reserved, and inserting in lieu thereof a new Code Section 49-4-156 to read as follows:

49-4-156.

The provisions of Code Section 33-21-16 shall not apply to health maintenance organizations with respect to contracts entered into with the department for the furnishing of health care services to persons pursuant to this article.

SECTION 4.

Article 13 of Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to PeachCare for Kids, is amended by striking Code Section 49-5-272, relating to definitions, and inserting in lieu thereof the following:

49-5-272.

As used in this article, the term:

(1) 'Board' means the Board of Community Health.

(2) 'Department' means the Department of Community Health.

(3) 'Federal law' means Title XXI of the federal Social Security Act.

(4) 'Medicaid' means medical assistance provided under Article 7 of Chapter 4 of this title, the 'Georgia Medical Assistance Act of 1977.'

(5) 'PeachCare' or 'program' means the PeachCare for Kids Program created by Code Section 49-5-273.

SECTION 5.

Said article is further amended by striking subsections (g) through (o) of Code Section 49-5-273, relating to the creation of PeachCare, availability, eligibility, payment of premiums, and enrollment, and inserting in lieu thereof the following:

“(g) The department shall provide for outreach for the purpose of enrolling children in the program. Applications shall be accepted by mail or in person. All necessary and appropriate steps shall be taken to achieve administrative cost efficiency, reduce administrative barriers to application for and receipt of services under the program, verify eligibility for the program and enforce eligibility standards, and ensure that enrollment in the program does not substitute for coverage under a group health insurance plan.

(h) Any health care provider who is enrolled in the Medicaid program shall be deemed to be enrolled in the program.

(i) The department shall file a Title XXI plan to carry out the program with the United States Department of Health and Human Services Centers for Medicare and Medicaid Services. The department shall have the authority and flexibility to make such decisions as are necessary to secure approval of that plan consistent with this article. The department shall provide a copy of the plan to the General Assembly. The department shall operate this program consistent with federal law.

(j) The department shall publish an annual report, copies of which shall be provided to the Governor and the General Assembly, setting forth the number of participants in the

program, the health services provided, the amount of money paid to providers, and other pertinent information with respect to the administration of the program.

(k) All state agencies shall cooperate with the department and its designated agents by providing requested information to assist in the administration of the program.

(l) The department, through the Department of Administrative Services or any other appropriate entity, may contract for any or all of the following: the collection of premiums, processing of applications, verification of eligibility, outreach, data services, and evaluation, if such contracting achieves administrative or service cost efficiency. The department, and other state agencies as appropriate, shall provide necessary information to any entity which has contracted with the department for services related to the administration of the program upon request. For purposes of compliance with Code Section 34-8-125, a request by any entity which has contracted with the department for services related to the administration of the program shall be deemed to be a request by a responsible official of the department and considered to be a request by the department.

(m) Nothing in this article shall be interpreted in a manner so as to preclude the department from contracting with licensed health maintenance organizations (HMO) or provider sponsored health care corporations (PSHCC) for coverage of program services and eligible children; provided, however, that such contracts shall require payment of premiums and copayments in a manner consistent with this article. The department may require enrollment in a health maintenance organization (HMO) or provider sponsored health care corporation (PSHCC) as a condition of receiving coverage under the program.

(n) The Department of Education and local boards of education shall cooperate with and provide assistance to the department and its designated agents for the purposes of identifying and enrolling eligible children in the program.

SECTION 6.

This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval.

SECTION 7.

All laws and parts of laws in conflict with this Act are repealed.